Annual 2008 VA/DoD Joint Venture Conference

Tripler Army Medical Center and VA Pacific Islands Health Care System

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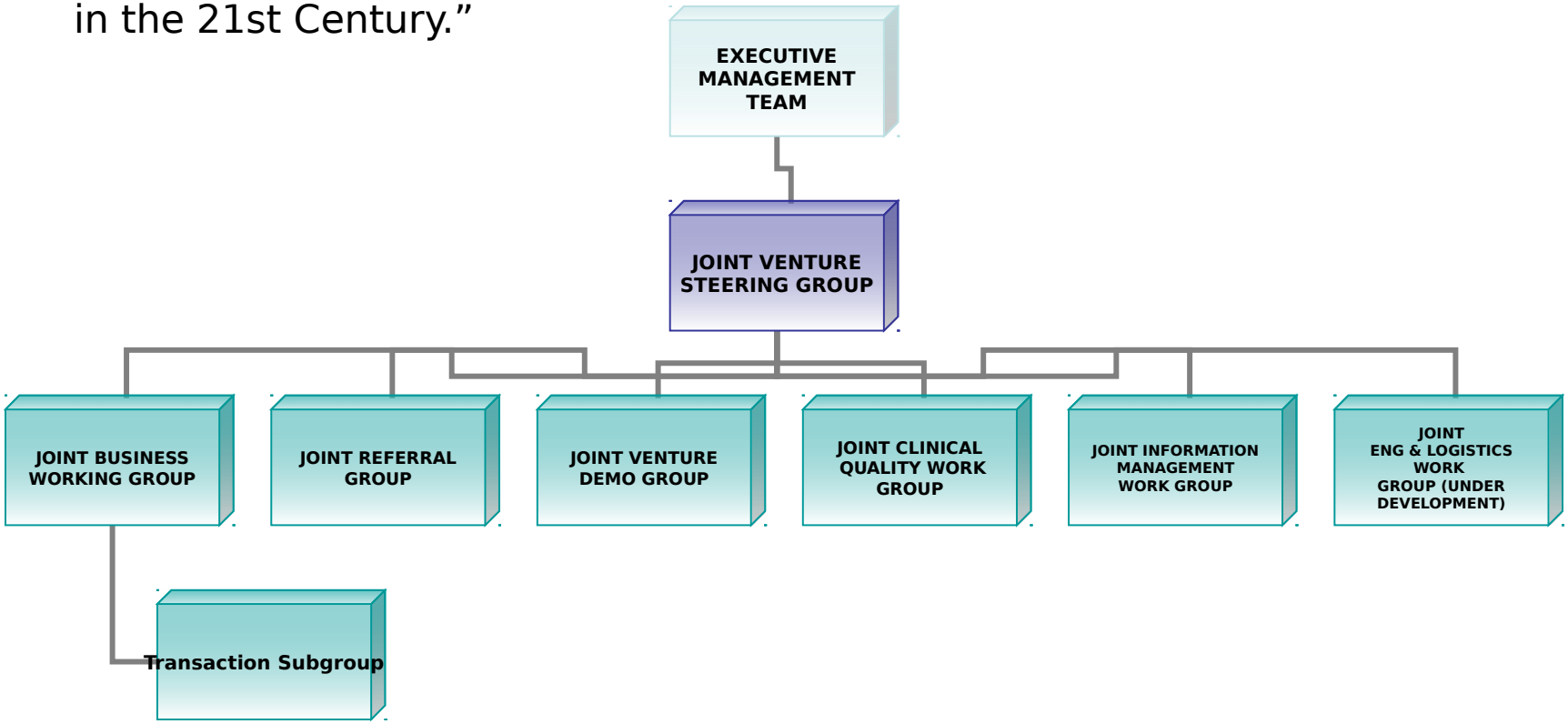
Agenda

- Brief overview of sharing relationship
- Describe one aspect of your sharing relationship that is most successful.
  - What is the sharing arrangement?
  - What makes it successful?
  - What are the reimbursement methodologies used?
  - What challenges/barriers occurred?
    - How were they solved?
- Other best practices at the Joint Venture
- Lessons Learned
- Contact Information

Overview of Sharing Relationship

Overview of Sharing Relationship

- **Mission** “Caring and Working Together…Pacific Regional Medical Command and the VA Pacific are committed to providing our beneficiaries the finest health care in the Pacific.”
- **Vision** “To be the model DoD/VA integrated comprehensive health care system in the 21st Century.”



What is Successful

- Size and complexity of the Joint Venture program
- Maturity of the Joint Venture program
- Ability to develop new initiatives as opportunities are identified
- Development of the working group structure

What makes it Successful

- Communication, Communication, Communication, Communication, Communication, Communication, Communication, Communication
- TAMC and VAPIHCS Leadership support
- Dedicated staff who work day-to-day issues/concerns
- Island limitations for specialty care
- Seeking win-win solutions
- Integrity and trust
- Ability to think “out of the box” (ROFR, shared providers, support staff)

Reimbursement Methodology Used

- **Inpatient** – IAW VA-DoD Health Care Resource Sharing Rates-Billing Guidance for Inpatient Services with added charges for discharge medications, specialized equipment and supplies, “other than acute” admits/outliers; observation (hourly), and readmissions
- **Professional charges** – based on rounds visits
- **Psychiatric** - Per diem charge
- **Outpatient** – IAW HA/VHA guidance for OP Services (CMAC minus 10%); default to CMS RVU/APC tables for missing/incomplete codes; Orthotic support at actual cost
- **Emergency Room** – CMAC minus 10%; transport at flat rate per trip
- **Ancillaries** - Lab & Rad (CMAC minus 10%); Autopsy Services (flat fee/autopsy); Pharmacy - TBD

Reimbursement Methodology Used

- **Non-medical/Other**

  -- PRRP (overhead costs plus NCD, linen, and IM/IT support)

  -- Radiation Protection (cost/hr)

  -- Security & Med Maintenance (FTEs)

  -- Housekeeping (contract and COTR)

  -- Food Service (varies by type of support)

  -- CMS (FTE support, supplies & associated costs)

  -- Dental Support (ADA costs)

  -- Consumer Price Index used for inflation year to year

Challenges/Barriers What occurred/How it was solved

CHALLENGE/BARRIER	RESOLUTION
Late Billing	Earlier development and signature of the RM; implementation of the National Agreements; creation of working sub-group
Agency/Service policies do not consider impact on VA/DOD resolve Sharing Agreements	National joint policies vs each site attempting to
Lack of interagency IT business application software	'DR' and Enhanced 'DR' bidirectional business software
Workload not captured in VA systems	Modify VistA Fee
Interpretation of bartering accounting" vs guidance	Consider "value cost accounting

Other Best Practices at the Joint Venture

- Created local joint policies
- MSA covers only stable core elements of sharing arrangement
- Overcoming “we” vs “them” mentality
- Recognizing differences, yet reaching consensus
- JIF benefits 50-50 wherever possible

Lessons Learned

- Communication is essential
- Document agreements/understandings
- Trust and Integrity
- Patient-centered focus
- Multi-disciplinary teams are essential in the development of initiatives